10 tips for writing about the growing number of older doctors

By Cheryl Clark

Are there doctors in your city/county/state who are too old to practice? How do you tell? And who's to say?

One option underway at some facilities is to establish a policy to regularly screen older providers for mental or physical competency before they're allowed to see patients. Some organizations are making this a condition of medical group membership or hospital staff privilege. But at what age should testing begin? 65, 70, 75? And what should be done with them if their scores aren't quite up to par? Should all clinicians who touch patients be tested?

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Warning: This is not an easy story to tackle. But regardless of where you live or who your readers are, it's an important one that could impact the supply of providers in your area.

It certainly hit a raw nerve with MedPage Today readers because the first of the three stories I wrote in March in a series on the topic has generated the 10th largest number of page views for the entire site since Jan. 1, 2017, and garnered one of the highest numbers of comments, as of May 17.

The issue is this: The number of physicians who have marked their 65th — even their 70th, 80th or 90th birthdays — has been growing, according to the American Medical Association's Masterfile, which keeps track of the nation's physician workforce. Their share of the workforce also may also be increasing, meaning that a patient might be more likely to see a senior doctor than one a few years out of residency.

A November report from the AMA's Council on Medical Education placed the number over age 65 in 2017 at 300,752, or 26.6% of all doctors in the nation. That's up from 241,641 in 2013.

Not all of these senior doctors are still practicing but some 40.6% are still listed as actively engaged in patient care.

Many are surgeons or other interventionalists who perform invasive procedures, injections or infusions in their clinics, ambulatory surgical centers or even in their offices, away from hospital oversight.

Of course, in all likelihood, most are considered an essential part of their community's provider workforce, especially in rural or lower-income areas where certain specialties or expertise may be in short supply, and their departure would delay or eliminate access to care for the underserved.

In some towns, many of these doctors are well-known institutions and leaders. They have cared for whole families from birth to death. They know their patients' life stories. They're good doctors, and their patients trust and depend on them.

Older doctors have more experience than their younger colleagues. They may be more compassionate, have more wisdom, and may be able to tolerate stress a lot better, according to the AMA Council's report.

But can they keep up with the latest medical advances, drug dosages and ever-changing warnings, latest practice guidelines and requirements to take patients' histories on a computer rather than the old way, on a pad of paper like my septuagenarian internist still does? (He uses an EHR as well but, like many older physicians, he feels more comfortable talking with me face to face, with a notepad, rather than staring away from me to fill out my chart on his computer.)

As one senior physician commented, "What do we do with this guy who is 89 years old and can't remember how to get to the OR anymore?"

Why don't they retire? According to that AMA report, seniors in general are living longer and staying healthier. Some doctors told the AMA committee they need extra years of earnings to compensate for losses during the 2008 recession. Other reasons older doctors gave are that

1. they cherish the professional satisfaction they get from their work and
2. they think they provide better care than their younger colleagues because they're more dedicated and serious about it.

I sensed from my interviews with doctors that these two reasons probably override any others.

A recent JAMA Surgery article bore that out. It used results from a survey of surgical department chairs to conclude that, at least for surgeons, many avoid retirement because they never got around to having outside interests, having been so dedicated to clinical activity their whole lives. Or, they said they don't think younger doctors "share their own level of commitment or capability." Older generations of surgeons embrace a work-life balance "that favors career as a primary focus and priority" the authors wrote. Besides, even if some

surgeons do retire from their surgical suites, they don't necessarily stop practicing, as this commentary in the same JAMA issue noted.

So what's the story for your readers, viewers or listeners?

It's this:

Efforts are looming, perhaps in your area, which would require your doctors and maybe even other clinicians to be screened at a certain age for cognitive abilities or physical dexterity that could result in more doctors retiring before they planned to, and perhaps before they should. Some, perhaps in defiance or fear of the embarrassment such screening programs might bring, will move their practices to another setting that doesn't require them to take a test when they get old. I know this is happening in my part of the world.

AMA members believe that if they don't start talking about this topic, and develop a national policy on screening older clinicians that is ethical and fair, a policy will be imposed on them — perhaps by licensing agencies, health plans, medical groups or hospitals, or even medical malpractice carriers — that won't be to their liking. What they seem to be suggesting is that there should be standards set on what tests should be used, what qualifications those who administer the test should have, when the tests should start, how results should be interpreted and by whom, and what should be done with the results. There should be, some say, acceptable alternatives for doctors who aren't quite who they used to be that don't knock them out altogether.

They especially want to prevent organizations from creating systems that are really designed to just get rid of the oldsters who some think are just in the way.

"It is critical that physicians take the lead in developing standards for monitoring and assessing their personal competency and that of fellow physicians to head off a call for nationally implemented mandatory retirement ages or imposition of guidelines by others that are not evidence based," the AMA council wrote.

Already, some medical groups mandate retirement at a certain age, or limit profit sharing and access to benefits. That's the case at Southern California Permanente Medical Group which imposes a mandatory retirement age of 65. They can continue to work at the discretion of the medical director but usually at an hourly rate and no more than 20 hours per week. "As a result, few Permanente physicians work until age 70 or older," the council report said.

A major anesthesiology medical group that supplies doctors to dozens of Southern California hospitals has a hardline cutoff at age 70.

What has happened to these doctors who were forced out? I know several who just quietly moved over to federally qualified health centers or now work locum tenens at hospitals that don't have screening policies. You see the potential problem there.

There are systems to discipline and corral doctors who shouldn't be practicing, of course. Referrals of physicians for competency evaluation, also called "fitness for duty" programs, occur after a physician's behavior or malpractice came under licensing review. They can eventually stop some impaired physicians from continuing to treat patients, or at least impose limits or oversight on their scope of practice. But these processes can take years, during which the physician continues to see and potentially endanger patients with a wrong medication dose, a wrong diagnosis or an inappropriate or neglected referral.

San Diego Scripps Health's solution, now in the process of being adopted for all of its hospitals and clinics, requires all affiliated clinicians — physicians as well as podiatrists, nurse practitioners, dentists and many other health providers — to undergo physical and cognitive screening at age 70 and every two years as they renew their staff privileges, which provides them the right to call themselves a Scripps provider.

The plan is to require them to take the PACE Aging Physician Assessment or "PAPA" program, administered by the University of California San Diego, if they want to renew their staff privileges every two years. The PAPA program is multifaceted, but it includes the MicroCog, an hour-long test in which the clinician sits alone in a room in front of a computer answering questions that challenge the ability to do math, make associations and recall details from a story. No mobile devices or pens are allowed, so those being tested can't take notes, and must solve these problems in their heads.

Legacy Health, a large health care system in Oregon, is requiring such screening of all its clinicians 70 years and older including the MicroCog. Intermountain Health in Utah has also had this policy. Sharp Rees-Stealy, a San Diego medical group with nearly 600 physicians, has screened its clinicians starting at age 70 since 2016 as an alternative to its now-defunct mandatory retirement policy.

Stanford University still has an extensive screening program, but dropped use of the MicroCog computerized test after getting pushback from faculty who doubted evidence that it affected the safety of patient care. Faculty argued the false positive and false negative rates — said to be 4% and 17% respectively — incorrectly label too many physicians who aren't cognitively impaired and miss too many who are.

The issue of the aging doctor is such a hot one that the hospital drama show "New Amsterdam" featured a segment on Jan. 22, 2019, that delved into the issue of older doctors, in this case a surgeon who was still operating with a tremor.

Needless to say, but I'll mention it anyway: many doctors are defensive and furious at this trend, calling it age-discrimination and other terms I'll spare you. If these systems are so hellbent on screening doctors, they should also screen those in younger age groups where they'd find far more incompetent providers, these doctors say. They should test other providers who touch patients and make decisions that impact patient care as well, such as nurse practitioners, dentists, podiatrists and pharmacists, as a condition of affiliation with that health care system.

Besides, how can anyone say a doctor has declined without a baseline? Maybe screening should begin at age 40? they ask. And who is going to pay for all this testing?

The truth of the matter is that we all experience declines in our capacity to think and function as we age, and research shows that 65 or 70 seems to be the magic time that these abilities start to go south for most of us. In general, those skills physicians need to provide care, such as working memory, the ability to store and process information, not to mention see and hear with clarity, just aren't as good.

Not for everybody, of course. But what experts told me is that at older ages, there are wider gaps between high and low performers than in

cohorts of doctors tested in younger age brackets. Some physicians in their 80s may score as high as or higher than some doctors in their 40s, while some score far, far below.

So how do you tailor this story for your readers?

1. First, get the numbers

See how many older doctors are still practicing in your city, county or state. Your state medical boards should have this information, if not by specific age, by year of medical school graduation which gives you an idea. Sometimes, however the files can be obtained only through more sophisticated data programs like Access. County medical societies also have this data and my local San Diego County society shared some of its data with me.

With the numbers sorted, one can see how many clinicians who graduated from medical school before 1965, when they were at least 26, still have active licenses and in what parts of your region they practice, and in what specialties. Are all of the ophthalmologists in your town over 65? A phone call to their office would tell whether they are still practicing full time or part-time.

2. Talk to older doctors

Don't be afraid. Call up a few senior physicians that you know in your community and ask them about this trend. If you can't get through the reception desk, find some doctors in your neighborhood or who are friends of friends. Undoubtedly, they've heard about this issue and may know of some local health systems or medical groups that have started talking about the idea of launching some sort of screening program if they aren't already doing so. Most will probably admit that they know something needs to be done. They know a few colleagues who shouldn't be practicing.

So far, I haven't found any late-career doctors who are offended by my questions about this issue. Most were eager to talk about it saying they believe they themselves will know when it's time for them to stop practicing and "it's the other guy we have to worry about." Check medical malpractice files and of course their medical board records too, to make sure your sources aren't already problematic.

And my favorite pro tip: Record — with consent — all of your conversations with these doctors. Trust me on this. If your sources object, don't do the interview. You want to be able to use what you hear, and you don't want any confusion about what is agreed to be off the record or on background. Recording your conversations also lets your sources know you are serious about writing an honest and balanced story, and retains the context of your questions and responses. [Note: there are different consent laws depending on the state you, and your interviewee reside]

One of my sources in San Diego, Jim Hay, M.D., said that journalists might have better luck getting physicians to talk about this topic if they offer to let their sources see all quotes before publication. He realizes that some journalists won't go for that, and I mentioned to him that some media groups' policies prohibit it, but he thinks "it will get more docs willing to be open." Or, you could read back the quotes you're planning to use.

3. Ask about screening policies

If you haven't been able to find out from your sources, ask your hospitals' medical executive committees and larger medical groups what their policies are regarding recredentialing their clinicians, a determination they must make every two years, and whether they have separate policies for testing senior clinicians at a certain age. Leaders of large medical groups or specialty groups and clinics might answer this question as well.

4. Find out how hospitalist models have affected practices of senior doctors.

This gets tricky because many hospital systems have adopted hospitalist models that have eliminated requirements that their community doctors take calls, spend time in the emergency room, write orders or visit for their patients when they're admitted. No more do these aging community doctors share stories or fellowship in the doctor's lounge. Practically speaking, they've become strangers to those doctors practicing within the hospital or its outpatient clinics, and strangers to those on the peer review committees. Years have gone by.

Many community physicians who are not hospitalists have confided to me that if they visit their patients on the hospital wards now, it's seen as possibly interfering with or delaying plans of care, which is at odds with the hospitalists' need to expedite patient flow, to make room for more revenue-producing patients. So they stay away.

Thus, hospital teams are unaware of a doctor's lapse in care or that a 75-year-old gastroenterologist who now works only out of his own endoscopy suite has developed a tremor.

The hospitalist trend may have hastened policies to screen doctors who no longer attend to patients within the system's facilities, and who may be 10 years older than the last time any committee member saw them in person. Ask if the hospitalist model has perhaps expedited consideration of screening policies as a way for organizations can now keep track of affiliated clinicians they no longer know first-hand.

5. Ask your state licensing agency

State licensing agency officials might have opinions on whether late-career physicians are more or less likely to be the subject of a disciplinary action than younger cohorts. And there is some PubMed data on this topic, although some doctors question its reliability.

State officials, of course, are unlikely to say but the boards may provide the names of some doctors who are accused of age-related competency issues. Keep in mind, that there are fewer doctors practicing in older age groups and some doctors self-limit what they do or how many hours of care they provide - things the medical board probably does not know about so any data you get can be problematic.

If you have time, sample the board's last 50 to 100 accusation documents to see how many of them have recommended the physician undergo competency review, and how many of them were practicing into their 70s or 80s. What happened to those doctors and how long did it take for a resolution of the case?

6. Medical malpractice claims

I called several medical malpractice carriers to ask if late-career physicians had higher rates of claims, either in volume of claims or dollars paid, and the answer was no, they did not. But you might ask these same questions of your regional carriers.

7. Other industries?
Compare screening policies in other industries or occupations, such as airline or military pilots, bus drivers, train conductors, police or firefighters, and examine what screening tests they undergo at a certain age.

8. Success and failure
For those organizations that are conducting age-based screening using certain computerized tests, try to find out pass/fail rates for certain age brackets, and how those results might be interpreted differently depending on who is administering the test.

I'm told some organizations that provide physician testing services for medical groups, hospitals or state licensing agencies differ on what they consider a failing score. These numbers will be tough to get. They were for me, because many organizations

a) may be reluctant to reveal how many older doctors they have on staff who undergo testing every two years, and

b) they may not have screened enough clinicians to reach statistical significance for certain age brackets and don't want to lump 67 to 70-year-old doctors with 80-year-old plus ones because there may be a big difference.

9. Ask some lawyers.
What do medical malpractice attorneys (both those who defend doctors and those who sue them) have to say about the need for screening older clinicians?

10. Other stakeholders' reaction
Get reaction from larger employers, health plans and consumer groups serving your region on whether they feel safer knowing their doctors undergo screening at a certain age, or whether such efforts may prompt some perfectly capable, wise and empathetic physicians to move on.

Here are a few pieces I've written in the last four years on this topic, plus a recent New York Times piece on screening of senior surgeons.

- May 7, 2019 • Meet the MicroCog. You May Soon, Whether You Like It or Not — Docs worry about accuracy of commonly used cognitive screening tool
- March 21, 2019 • You're 70 — It's Time You Underwent Skills Testing — Is this what age discrimination looks like?
- March 14, 2019 • Doddering Doctors: Hospitals Take a Stab at Weeding Them Out — Screening programs take shape in San Diego as nationwide trend gains steam
- Aug. 18, 2015 • Hospitals, medical groups start to worry about skills of older doctors
- Aug 6, 2015 • Aging Docs: Contractor Offers Turnkey Assessment; PAPA may have the answer
- July 30, 2015 • Out to Pasture: Age-Based Personnel Policies Rankle With Docs — But some health systems like hard age cutoffs as a 'bright line'
- June 29, 2015 • Aging Doctors: Time for Mandatory Competency Testing?
- Feb. 1, 2019 • When Is the Surgeon Too Old to Operate?

Resources:

Organizations with late career physician policies either in place or in development:

- Cooper University Health Care in Camden, New Jersey
- The University of Virginia health system in Charlottesville
- Driscoll Children's Hospital in Corpus Christi, Texas
- Scripps Health, San Diego (chief medical officer James LaBelle, M.D.)
- Sharp Rees-Stealy Medical Group, San Diego (medical director Steve Green, M.D.)
- College of Physicians and Surgeons of Ontario, Canada
- Virginia Commonwealth health system, Richmond
- UCSD Medical Center, San Diego
- Stanford University Medical Center – Stanford, California

Other sources
The American Medical Association's Council on Medical Education's 2015 report, "Assuring Safe and Effective Care for Patients by Senior/Late Career Physicians" and its 2018 report, "Competency of Senior Physicians." These reports reference links to numerous studies, commentaries and other documents on the topic of performance of the aging physician.

Journal of Medical Regulation, April 2019, report "State of the Science on Risk and Support Factors to Physician Performance: A report from the Pan-Canadian Physician Factors Collaboration."

Richard Barton, attorney for hospitals and medical groups in San Diego who helped write 2015 report, a set of guidelines, for establishing policies that screen senior physicians. rick.barton@procopio.com

Jim Hay M.D., former president of the California Medical Association and a Southern California family doctor who helped write the 2015 report on the need for a policy on screening senior physicians. Hay is an opposing voice. jthay@ncfmg.com

David Bazzo, M.D., head of the PACE Aging Physician Program, a screening program for late career physicians based at the University of California San Diego. PAPA is a parallel program to PACE, UCSD's Physician Assessment and Clinical Education program, which assesses doctors for cause, when medical groups or hospitals or a state medical board document a concern about the physician's behavior, sometimes after a medical error has harmed a patient. dbazzo@mail.ucsd.edu

Lauri Korinek, Ph.D., neuropsychologist with the Center for Personalized Education for Professionals or CPEP program in Denver. CPEP is generally like the PACE program in San Diego but is starting to offer a screening service for late career physicians. Korinek shared her dissertation, which goes into a lot of detail on the MicroCog computerized screening test used by many hospitals and medical groups with age-based screening mandates. lauri@hopeandgrowth.pro

Beth Korinek, CEO, Center for Personalized Education for Professionals, 303-577-3232 x 0, bkorinek@cpepdoc.org

Kelly Garrett, Ph.D, neuropsychologist with Intermountain Healthcare in Salt Lake City who directs the screening program for her health care system. Kelly.Garrett@imail.org

Claire Wolfe, M.D., physiatrist and former member of the AMA's senior physicians section. cwolfe@columbus.rr.com She is semi-retired now and may have time to talk about this issue.

Alice Reed, group manager of the AMA's senior physicians section. Alice.Reed@ama-assn.org

Kelly Jakubek, media relations manager of the AMA. Kelly.Jakubek@ama-assn.org

Michelle McComber, CEO, Utah Medical Association, which does not favor programs that screen late career physicians just on age. In Utah, I'm told, the healthy lifespan for males, who make up most of Utah's physicians, is longer than it is in most other states so Utah has a lot of older doctors. michelle@utahmed.org